East Lothian
Health & Social Care Partnership

Duty of Candour Annual Report

for Adult Social Work

1st April 2020 – 31st March 2021

East Lothian Health & Social Care Partnership	Duty of Candour Lead: Isobel Nisbet
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DUTY OF CANDOUR ANNUAL REPORT
EAST LOTHIAN HEALTH & SOCIAL CARE PARTNERSHIP

SOCIAL CARE SERVICES

For

ADULT SOCIAL WORK

All health and social care services in Scotland have a duty of candour. This is a legal requirement which means that when unintended or unexpected events happen that result in death or harm as defined in the Act, the people affected understand what has happened, receive an apology, and that organisations learn how to improve for the future.

An important part of this duty is that we provide an annual report about how the duty of candour is implemented in our services. This short report describes how East Lothian H&SCP Social Care Services has operated the duty of candour during the time between 1 April 2020 and 31 March 2021. We hope you find this report useful.

1. About East Lothian Health & Social Care Partnership (H&SCP)
East Lothian H&SCP serves a population of 107,900 (June 2020[1]) people across East Lothian. We cover a diverse geographical area, including large and small towns as well as rural areas. Our aim is to provide high quality care for every person who uses our services, and where possible help people to receive care at home or in a homely setting.

2. How many incidents happened to which the duty of candour applies?
Between 1 April 2020 and 31 March 2021, there was **one incident** where the duty of candour applied. (I.e. these are unintended or unexpected incidents that result in death or harm as defined in the Act, and do not relate directory to the natural course of someone's illness or underlying condition.)

Through the adverse event process, we determine if there are factors that may have caused or contributed to an event, which helps to identify duty of candour incidents.

Type of unexpected or unintended incident (not related to the natural course of someone's illness or underlying condition)	**Number of times this happened (between 1 April 2020 and 31 March 2021)**
A person died	1
A person incurred permanent lessening of bodily, sensory, motor, physiologic or intellectual functions	0
A person's treatment increased	0
The structure of a person's body changed	0
A person's life expectancy shortened	0

[1] National Records of Scotland nrscotland.gov.uk

A person's sensory, motor or intellectual functions was impaired for 28 days or more	0
A person experienced pain or psychological harm for 28 days or more	0
A person needed health treatment in order to prevent them dying	0
A person needing health treatment in order to prevent other injuries as listed above	0
Total	1

Did the responsible person for triggering duty of candour appropriately follow the procedure? If not, did this result in any under or over reporting of duty of candour?	Yes. Between 1 April 2020 and 31 March 2021, there was one incident where the duty of candour applied for Adult Social Work Services. This was in relation to the death of an adult in receipt of care at home services commissioned by the Local Authority to be delivered by an independent provider.
What we did in response to the incident to which the duty applied	We acknowledged our Duty of Candour and advised next of kin of this, setting out a number of areas for further inquiry.
What lessons did we learn?	An internal report was prepared outlining the circumstances of the death of the adult which identified areas of learning. The adult unfortunately died due to reasons associated with physical health. There was no indication that the actions or inactions of agency or Partnership staff could be attributed to her death. The report was shared in full with the adult's family who were invited to give comment and meet with senior managers. A referral was also made to our Public Protection Office who instigated an Initial Case Review which included a multi-agency contribution.
What learning & improvements have been put in place as a result?	NA
Did this result in a change / update to our duty of candour policy / procedure?	NA
How did we share lessons learned and who with?	NA
Could any further improvements be made?	The commissioned service ceased to exist shortly after the death of the adult. The staff and service users transferred to a newly formed company. The circumstances of the adult's death along with other concerns relating to the new service contributed to actions under our

	Large Scale Investigation protocol due to further Adult Support and Protection concerns.
What systems do we have in place to support staff to provide an apology in a person-centred way and how do you support staff to enable them to do this?	All staff have access to the NES online training module on duty of candour via ELC Learnpro. Our reporting system picks up if any incidents are reportable and this cascades into our quality governance reporting. DoC is part of our overall approach to managing incidents. In the event of any incidents staff would be supported by a senior manager and all apologies would be offered verbally and in person and ideally involve the staff member, if appropriate. .
What support do you have available for people involved in invoking the procedure and those who might be affected?	NA
Anything else that may be applicable to report.	NA

3. Other information

This is the third year of the Duty of Candour being in operation.

As required, East Lothian H&SCP has submitted this report to the Care Inspectorate and we have also placed it on our website and the intranet. In addition, the CSWO has made reference to Duty of Candour data in the annual CSWO report, with information being taken from the Duty of Candour annual report.

If you would like further information regarding this report, please contact:

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